

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN4711	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  09/23/2015
NAME OF PROVIDER OR SUPPLIER  KINDRED HEALTH AND REHABILITATION-NOF		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 BROADWAY NE KNOXVILLE, TN 37917		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments  A Licensure survey and complaint investigation (#37395), were conducted at Kindred Health And Rehabilitation-Northhaven from 9/21/15, through 9/23/15. No deficiencies were cited in relation to the survey and complaint investigation (#37395), under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

J. Michelle Brakel

Executive Director

10/15/15

STATE FORM

6899

9C7711

If continuation sheet 1 of 1